UNITED STATES BANKRUTCY COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

IN RE:	:	**Chapter 11**
Circuit City Stores, Inc., et. al.	:	**Case No. 08-35653 (KRH)**
Debtors	:	**Jointly Administered**

RESPONSE TO DEBTOR'S OMNIBUS OBJECTION OF CLAIMS AND A REQUEST FOR A HEARING

PLEASE TAKE NOTICE THAT MARY LOPRESTI, claim number 5401, hereby opposes the relief requested in the Objection. Pursuant to a Notice of Debtors Omnibus Objection to claims dated August 20, 2009, the following is offered in support of this Response:

A. The claimant's name is Mary LoPresti. The amount of the claim is $5,000.00 as compensation for personal injuries sustained on August 31, 2008 while shopping at the Circuit City Store in North Haven, Connecticut.

B. Attorney Sally J. Buemi, 270 Quinnipiac Avenue, North Haven, Connecticut 06473, (Telephone 203-865-5567) is familiar with the relevant facts that support this Response. Mary LoPresti, a business invitee, was shopping at the North Haven Circuit City. A store employee was assisting her, and this employee caused a large stereo speaker to fall from a shelf and onto her left foot causing a contusion and swelling, and pain that lasted for several months. The supporting medical bill and report

are attached. The store employee was negligent in causing this speaker to fall on the claimant. Store management made a report of this incident at the time.

C. The Claimant's address is 28 Schupp Road, Hamden, Connecticut 06514 (Telephone 203-288-6184)

Claimant's Attorney: Sally J. Buemi
270 Quinnipiac Avenue
North Haven, CT 06473
203-865-5567
Fax # 203-562-3489

Attorney Sally J. Buemi has the authority to reconcile, settle or otherwise resolve the objection on the Claimant's behalf.

The Claimant requests a hearing on this Response to Debtors' Objection.

Dated September 9, 2009 at North Haven, Connecticut.

Sally J. Buemi
Attorney for Mary LoPresti
270 Quinnipiac Avenue
North Haven, CT 06473
Telephone: (203) 865-5567
Juris No.: 102349

CERTIFICATION

I hereby certify that a copy of the foregoing Response was mailed, via U.S. Mail, postage pre-paid, on September 9, 2009 to the following:

Skadden, Arps, Slate, Meagher & Flom, LLP
One Rodney Square
P.O. Box 636/ 10th + King Streets, 7th Floor 19801
Wilmington, DE 19899-0636
Attention: Gregg M. Galardi
Attention: Ian S. Fredericks

Skadden, Arps, Slate, Meagher & Flom, LLP
155 North Wacker Drive
Chicago, Illinois 60606
Attention: Chris L. Dickerson

Mcguirewoods, LLP
One James Center
901 E. Cary Street
Richmond, VA 23219
Attention: Dion W. Hayes
Attention: Douglas M. Foley

Sally J. Buemi
Attorney for Claimant Mary LoPresti

Yale University Health Services
17 Hillhouse Avenue
P.O. Box 208237
New Haven, CT 06520-8237

Urgent Care

Patient: MARY B. LOPRESTI
28 SCHUPP ROAD

HAMDEN, CT 06514

MRN: 00140539
Age/DOB: 56/Feb 29, 1952

Home: (203)288-6184
Work: (203)737-2207

Note Owner: John Dailinger P.A.
Encounter Date: Sep 1 2008 9:45AM

Chief Complaint
• Mary reports pain and swelling of left foot. States a speaker fell on foot while in Circuit City last pm. --- LYVONDA TART, 09/01/2008, 10:04AM

HPI
Ms. Lopresti reports that while she was shopping last night, a speaker fell from a shelf, striking her on the left foot. She's had local pain and swelling since, and has a break in the skin at the area of impact. She is not experiencing any numbness or tingling, but has progressive pain with sustained weight-bearing.

Active Problems
Anxiety (300.00)
Bursitis (727.3); ischial
Menopause Oct 2004 (627.2)
Murmurs (785.2)
Open Wound Of The Finger(S) 03 Aug 2008; Left (883.0).

Current Meds
Oscal 500/200 D-3 TABS;TAKE 1 TABLET EVERY OTHER DAY; RPT
Lorazepam 1 MG Tablet;TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR ANXIETY; Rx.

Allergies
No Known Drug Allergy.

Vital Signs
Recorded by lt232 on 01 Sep 2008 10:00 AM
BP:143/77, Sitting,
HR: 76 b/min,
Resp: 16 r/min,
Temp: 98.2 F, Oral,
Pain Scale: 5.

Physical Exam
Exam reveals a very pleasant, healthy appearing woman who has initial antalgic gait when wgt-bearing on the left foot, but this seems to correct within 3 or 4 steps. Specific attention tothe left foot and ankle reveals dorsomedial swelling over the area of the tarsal navicula as well as a small abrasion in this area (2or 3mm in diam.). There may be some ecchymosis evolving, and there is local soft tissue tenderness but no elicitable bony tenderness. ROM of the ankle and foot is intact, as is tendon function. There is excellent strength of the ankle and foot in all planes, and no soft tissue crepitation. The ankle joint is stable on clinical stress exam., and distal color, temperature, and both dorsalis pedis and post. tibialis pulses are intact. There is no Achilles' tenderness or swelling, and x-rays are currently deferred.

Assessment
Contusion/abrasion of the left ankle/foot, with local soft tissue swelling/tederness.

Yale University Health Services
17 Hillhouse Avenue
P.O. Box 208237
New Haven, CT 06520-8237

MARY B. LOPRESTI /00140539/Feb 29, 1952

Plan
The situation was discussed with the pt., and rest, ice, elevation, daytime ace wrap or support hose were recommended as well as advil up to 3 tabs. taken three or four times daily with food (she has taken this much in the past without problems). If the situation worsens, she has my card and will contact me to arrange any further necessary f/u.

Coun/Edu
She is informed that it is not unusual for injuries similar to this to feel somewhat worse over the frist three to four days, and then plateau for up to a week for slowly beginning to improve. She is in formed that it may require as long as 4-6 weeks before the area feels normal. and some swelling locally, especially later in the day, may persist for a period of up to twice that. If things get worse or she has increased difficulty walkling despite the above measures, she'll contact me. She appears to have a good understanding of the situation and plan, and knows how to reach me if she has further questions.

Signature
Signed By: LYVONDA TART R.N.; 09/01/2008 10:05 AM EST; Co-author.
Signed By: John Dailinger P.A.; 09/01/2008 11:04 AM EST.
Signed By: John Dailinger P.A.; 09/01/2008 6:32 PM EST.

MARY B LOPRESTI
28 SCHUPP ROAD
HAMDEN, CT 06514

1500

225

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) [X] / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	041-48-6720 118542	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
LOPRESTI, MARY B	02 29 1952 M [ ] F [X]	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
28 SCHUPP ROAD	Self [X] Spouse [ ] Child [ ] Other [ ]	
CITY / STATE	8. PATIENT STATUS	CITY / STATE
HAMDEN / CT	Single [X] Married [ ] Other [ ]	
ZIP CODE / TELEPHONE (Include Area Code)	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE / TELEPHONE (Include Area Code)
06514 / (203) 288 6184		( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [X] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 924 21 2. 924 20 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 01 2008	11		99213	1,2	165 00	1		NPI	1346282639
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
060646973 [ ] [X]	I1927397	[ ] YES [ ] NO	$ 165 00	$ 0 00	$ 165 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
DAILINGER PAC, JOHN	URGENT VISIT TPL-SLIP/FALL	YALE UNIV HLTH SVCS - FFS P.O. Box 2052 New Haven, CT 06521-2052
SIGNED 771564 DATE 12/16/2008	a. b.	a. 1093062740 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER